

SENTARA HEALTH PLANS

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is NOT complete, correct, or legible, authorization will be delayed.**

Drug Requested: Palynziq™ (pegvaliase-pqpz) Injection

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

DRUG INFORMATION: Complete **all** information below or authorization will be delayed.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

CLINICAL CRITERIA. Check below **ALL** that apply. **ALL** criteria **must** be met for approval. **ALL** documentation, including lab results and/or chart notes (**when required**), **must** be provided or request will be denied.

INITIAL APPROVAL - 6 MONTHS

- Patient must be at least 18 years old
- Patient must have a diagnosis of phenylketonuria (**chart notes must be attached for documentation**)
- Provider must be a metabolic geneticist or physician knowledgeable in the management of phenylketonuria
- Baseline current phenylalanine levels must be >600 µmol/L **OR** average phenylalanine levels must have been >600 µmol/L for the last 6 months on existing management (**lab results from within the last 30 days must be attached**)
- Initial dose must be administered under the supervision of a healthcare provider and auto-injectable epinephrine must be prescribed
- Medication will **NOT** be used in combination with Kuvan®

(continued on next page)

- ❑ Patient must **NOT** have taken Kuvan[®] within 14 days of last phenylalanine lab **or** within 14 days of initial therapy with Palynziq[™]

CONTINUED APPROVAL - 6 MONTHS: **ALL** criteria below **MUST** be met for approval. **ALL** documentation, including lab results and/or chart notes (**when required**), **must** be provided or request will be denied.

- ❑ Patient must be at least 18 years old
- ❑ Patient must have a diagnosis of phenylketonuria (chart notes must be attached for documentation)
- ❑ Provider must be a metabolic geneticist or physician knowledgeable in the management of phenylketonuria
- ❑ Phenylalanine levels must have decreased by at least 20% from baseline **OR** phenylalanine blood levels must have decreased to ≤ 600 $\mu\text{mol/L}$ and continue to be maintained at those levels while on maintenance therapy (labs completed within the last 30 days must be attached)
- ❑ Medication will **NOT** be used in combination with Kuvan[®]

Medication being provided by a Specialty Pharmacy - PropriumRx

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

Previous Therapies will be verified through pharmacy paid claims or submitted chart notes.